Illinois Department of Healthcare and Family Services
Advance Practice Nurse (APN) Certification and Collaborative Agreement Form

Provider Information

Name Last	First	M.I.	Provider #	License #

Office Address	City	State	Zip

Office Phone ( )	After Hours Phone ( )	FAX ( )

APN Certifications Include: (Check all that apply)

	Certified Nurse Midwife		Certified Registered Nurse Anesthetist
	Certified Nurse Practitioner/ Speciality(s):		
	Clinical Nurse Specialist / Speciality(s):		

Collaborating Physician(s):

Physician Name	Physician Address	Physician FEIN	Physician License Number	State of Licensure

For CRNAs who are not required to maintain a collaborative or written practice agreement, list the following information:

Hospital Name	Street Address/City/Zip	Phone

Certification:

I certify that I meet the participation requirements for an Advance Practice Nurse. I also understand that I must notify the Department in writing should any changes to the information contained herein become necessary. I also understand that the information I enter on this form will be used to update the Department's data base.

Provider Signature : _____ **Date: _____**

Please mail your original signed copy to: **Healthcare & Family Services**
Provider Participation Unit
P. O. Box 19114
Springfield, Illinois 62794-9114

For More Information, call:(217) 782-0538